DOCUMENT RESUME

ED 043 907 CG 005 912

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TITLE Some National Developments in the Utilization of Nontraditional Mental Health Manpower.
INSTITUTION American Psychological Association, Washington, D.C.; Oregon Univ., Portland. Medical School.
PUB DATE Sep 70
NOTE 25p.; Presented at American Psychological Association Convention, Miami Beach, Florida, September 3-8, 1970

EDRS PRICE EDRS Price MF-$0.25 HC-$1.35
DESCRIPTORS Institutional Personnel, *Institutional Role, *Manpower Development, Mental Health, *Mental Health Programs, Patients (Persons), Personnel Needs, Program Development, Rehabilitation, *Rehabilitation Programs, *Therapeutic Environment

ABSTRACT

This paper presents a review of some of the new mental health manpower developments which have occurred in this country during the past two decades. The role played by the National Association for Mental Health (NAMH) in these developments is also viewed. Individuals working in state hospitals and related institutions have capitalized on the concept of the therapeutic community, with its principle that all employees and volunteers and other patients are potential rehabilitators and, as is appropriate in their setting, have begun inservice training programs and new mental health educational programs leading, in some local settings to: (1) an Associate of Arts degree; (2) a Bachelor of Science degree; (3) a Master of Arts degree; or (4) a n entirely new rehabilitation and direct treatment program. Through position papers supporting the above developments and conferences, NAMH has helped to further these developments by organization and communication of knowledge to others involved in the field. (KJ/Author)

SOME NATIONAL DEVELOPMENTS IN THE UTILIZATION OF NONTRADITIONAL MENTAL HEALTH MANPOWER[1]

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The thesis of this paper is that a review of current practices and realities in the employment of mental health manpower outside of the four core professions (psychiatry, psychology, social service and nursing) will reveal that while the membership of these four traditional mental health professions continues even today to debate the need for, and means of, recruiting other types of personnel to help provide services to this country's mentally ill and emotionally disturbed, other segments of society appear to have tired of waiting and have recruited, trained, and already put to work thousands upon thousands of nonprofessional persons whose major qualification in most instances was a desire to help their fellow man. A future historian or soiologist of the professions will be fascinated by his discovery of the professionals' slow-paced, decades' long diagnosis and search for solutions and the concurrent hundreds of haphazard, uncoordinated, community-initiated, seat-of-the pants solutions to equal numbers of critical local mental health manpower shortage problems. Each of the four professions has had its own high level committees,

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[1]Matarazzo, J. D. Some national developments. In M. L. Kumler (Chm.), Training mental health workers at varied professional levels: Psychology's role. Symposium presented at the American Psychological Association, Miami, September, 1970.

study groups, and national manpower conferences. And the conclusion reached (current need for services outdistances available or projected manpower supply) has been monotonously repetitious, with only the name of the profession changed in the final reports and conclusions of each of the four professions.

The unfolding of this drama for the field of psychology is representative. First there was Albee's 1959 tradition-shattering analysis of the current and projected manpower problem for psychology as well as for psychiatry, social work and nursing (Albee, 1959). His perceptive analysis of this country's number of youth and current and projected university resources revealed for the U. S. Congress, the core professions, and our educational institutions of higher learning that demand would continue to outdistance supply at an accelerated rate. Today, over a decade later, more current analyses of the same problem for psychology and, in some instances, the other three professions by Albee, Arnhoff, Boneau and others have shown that the worst of Albee's 1959 projections are coming to pass (Albee, 1968a, 1968b; Boneau, 1968; Arnhoff, 1968a, 1968b; Speisman, 1968; Arnhoff, Rubenstein, Shriver, & Jones, 1969; and Arnhoff & Boneau, in press).

This, then, is one piece of this fascinating puzzle for the future historian: psychology as one of the four core professions had clear information, based on hard data, that society's current and projected needs and demands would continue to outstrip the capacities of this profession, using simply our national manpower pool of talented young people as one of many hard indices, to meet these needs and demands.

In retrospect it is and has been enlightening for me, wearing my psychologist's hat, to ponder organized psychology's response to this set of hard data. First, it seems to me that responsible psychologists at every level (American

Psychological Association; in the universities; in federal government; etc.) have accepted the manpower projection data as both factual and compelling. One need only consult the report of the 1958 Miami Conference on Graduate Education in Psychology (Roe, Gustad, Moore, Ross, & Skodak, 1959, pp. 65-76) or the report of 1965 Chicago Conference on the Professional Preparation of Clinical Psychologists (Hoch, Ross, & Winder, 1966, pp. 39-45) to learn for himself that the representatives of APA, the universities, NIMH, VA, etc. were in agreement that the numbers of doctoral level psychologists could not and would not meet the needs of society for even the minimal projected estimates of psychology's fair share contribution of mental health personnel. In these two national conferences, and several others equally as important, the conferees spent a sizeable portion of their total conference time discussing the urgent need for the universities, the national organization, and other segments of organized psychology to begin to deploy some of their resources in the training of psychological assistants and other nontraditional mental health workers. I was a participant in the 1958 Miami Conference and in the 1965 Chicago Conference and remember well the urgency which both conferences ascribed to psychology's need to help train prebachelor, bachelor, and masters level people for work in the mental health field. There is no question in my mind that the motivation to develop a national plan for pooling psychology's resources toward this end was genuine and fairly universally present among the participants. Yet, by 1970, no such plan exists (see the last section of this paper). The same appears true of the experiences of the other three core professions.

Each of us will have his own explanation of why, through the year 1970, no one of the four core professions has developed a viable plan for educating and training the masses of persons apparently currently required to work with this country's

mentally ill, let alone emotionally or behaviorally disturbed. Inasmuch as this is not the place for me to develop my own views at any length, suffice it to say that even a superficial analysis of the supply-demand-recruitment problem will reveal that this tri-partite definition of the problem is too simplistic. I will elaborate some of the reasons why I believe this is so in my concluding remarks.

But, then, so far I have merely acknowledged that (1) numerous analyses of the supply-demand-recruitment problem affirmed the prediction that society's demands would continue to outdistance the supply of traditional, university-educated, mental health manpower, and (2) that each of the four core professions following reports of high level study groups and national conferences, both genuinely accepted this fact and publically committed itself to a search for a solution to the dilemma. Yet, frustratingly, no one of the four professions, nor coordinated leadership in its institutions of higher learning, has been able to produce a plan, even a pilot program, which would begin to ease the manpower shortage.

How, then, does one account for the numerous local experiments, the exciting nationally-distributed ferment, the massive influx of new ideas and, at first timid, but quickly becoming bold, new approaches to alleviating this country's mental health manpower shortage?

It is at this point that the future historian, if he is perceptive, will find that the consumer, the individual American needing the mental health service, has not been completely neglected during the past two decades of higher education and professional soul-searching. It was these critical needs of the mentally ill consumer which fortuitously coalesced with such striking changes in both our mental health delivery system and in our socio-political area as the advent of (1) the therapeutic

community concept, (2) junior colleges, and (3) career ladder and related New Frontier and Great Society programs for this country's disadvantaged citizens, that seems to have broken the deadlock.

During 1950-1965 the reports of innovative local approaches to alleviate human suffering due to shortages of mental health professionals were very few and all too-scattered throughout a number of professional journals. An isolated author, usually unknown to the country's university-based colleagues in his own profession, almost apologetically shared with this colleagues the insight that selected attendants in his hospital were being used in one-to-one roles with the patients on their own wards and some of these patients were being returned to the community. Another equally isolated practitioner wrote a paper reporting that highly selected and trained volunteers, from a local Mental Health Association, each visiting a patient once a week, seemed to be producing effects in his hospital's chronic, back ward mental patients that were highly impressive. There were many other scattered reports of similar nontraditional manpower utilization experiences in other communities, both with hospitalized patients and with those individuals receiving help in outpatient clinics.

From about 1960 to 1965, and with a clear assist from the Final Report of the Joint Commission on Mental Illness and Health entitled Action for Mental Health (1961), the concept of the therapeutic community received wide publicity in this country. The responsibility of hospital attendants (soon renamed psychiatric aides as a result of an NAMH-APA Joint Information Service national study of their responsibilities and potential functions) and registered nurses (also renamed psychiatric nurses) was no longer seen as primarily custodial. Rather, personnel in these two groups, plus members making up the rest of the hospital personnel (e.g., recreation and occupational

therapists, et al.) were acknowledged to be very potent agents for the rehabilitation of the hospitalized patient. Although presenting some "role-identity" problems for the professional staff of the four core professions in these state hospitals and clinics (see Shapiro, 1970; and also Roche Report, 1970 for a discussion of these problems), neither the 1960-65 concept of the therapeutic community nor the potent rehabilitative role of these aides, O. T.'s and other so-called ancillary, subprofessional workers presented insurmountable problems for these more traditional core professionals.

However, imaginative and highly effective local solutions to these pressing professional manpower shortages were much more numerous during this 1950 to 1965 period than any of us could have imagined at the time. Albee (1959, 1968a, 1968b) eloquently has affirmed and re-affirmed the fact that a shocking number of this country's state mental hospitals and psychiatric clinics did not have even a single psychiatrist on their full time staff. I feel certain that most readers, much as I did, momentarily recoiled at this startling revelation by Albee but soon left it to pursue other issues. From hindsight now, it is clear that some of the professional and allied professional persons who worked in these hospitals and clinics, and select individuals in many local communities, did not merely recoil. Rather, impressive evidence is now at hand that although uncoordinated and at first largely unrecognized outside their own community, refreshing, innovative, and highly effective solutions were being employed in a large number of state hospitals, clinics and other mental health facilities. These local solutions utilized no single manpower group but rather, as available in its own community, took advantage of a surprisingly heterogeneous set of heretofore neglected segments of the manpower pool making up its own local citizenry. Specific examples will be cited below. It is now becoming clear that beginning a decade ago,

the single physician, nurse, psychologist, or social worker practitioner in an isolated state hospital, finding himself solely responsible for a whole hospital, or two or three wards, was freed to a burst of innovative creativity by the concept of the therapeutic community with its key concept that each employee of the mental hospital was potentially a therapeutic agent. Almost overnight, and merely by a change in role definition and assigned responsibilities, such an administrator could transform his hospital from a one-physician or no-physician statistic in Albee's actuarially factual table, to a hospital with dozens of professionally trained, actively working subprofessionals requiring only modest supervision and the barest numbers of hours of additional training.

And, surprise of all surprises, these at first tentative steps taken by the core professionals in selected hospitals did not meet with disapproval either by representatives of the national professional organizations nor by leaders in the state's private and public institutions of higher learning. The latter groups already had seen the enormity of the supply-demand-recruitment problem and, as I now see it, in their informal and tacit endorsement of the 1961 Report of the Joint Commission, had provided the umbrella of professional approval and sanction for these innovative uses of other hospital personnel. When prestigious leaders in their respective professions such as Albee, Hobbs, and Smith et al. in psychology and H. Solomon, Greenblatt, and Lindemann et al. in psychiatry gave their clear support to the utilization of these previously ancillary hospital personnel in direct treatment roles, the utilization of such nontraditional mental health personnel accelerated and overnight increased the nation's potential mental health manpower supply by a factor of one, two, three, and more.

Interestingly, however, as these developments were unfolding in the

country's state hospitals, leaders in the universities, medical schools and other institutions of higher learning were able to contribute little to them directly. Anyone familiar with the steps and mechanisms required to affect curricular change or new curricular offerings in a university or medical school curriculum will not be surprised that such centers of learning could not immediately make their resources available in partnership with the inservice training programs being developed in the state hospitals. Practitioners and others who deliver services can, for example, utilize tranquilizers or elements of a therapeutic community or new inservice training programs within weeks or months of their becoming current at another hospital. With the requirement that curricular changes must be studied and approved by committees at all levels of their own hierarchies, university or medical school curricula once adopted seem, historically at least, to change at the most but once in each generation.

Within this context, then, it is not surprising that the practitioners in the state hospitals and community clinics whose responsibilities overnight were being transformed, turned for their educators in the main, not to the institutions of higher learning but rather to (1) hospital or community-based practitioners in the four core professions and (2) the faculties associated with a new development in this country's educational system, the community college. The latter, springing up in almost every community throughout America in the decade of the 1960's, had as one of its major responsibilities a mission quite different from that of the university; namely, to provide teachers and course offerings in practical fields for the already working adult as well as for the college age youth of America's lower middle and upper lower socio-economic classes. Before long the grammar and high school educated hospital attendant and the high school educated registered nurse, finding themselves with new professional

titles and new responsibilities as one-to-one therapists, learned that a course or two in psychology at the local community college could do much to accelerate the skills and concepts they had so effectively developed but not recognized by years of on the job training. Whereas, in some communities the story had ended with merely the assignment of these new professional roles, titles and responsibilities, in still others the new professionals went beyond this by also completing a few courses at the local junior or community college, or by asking the superintendent of the hospital to bring these same local teachers or actual local practitioners into the hospital for in-service training. Fortunately, in a surprising number of communities the demand from the hospital personnel for these courses and further training programs led to a full fledged 2-year curriculum offering leading to an Associate of Arts degree. A description of one of these now fairly numerous programs is provided by Danzig (Mental Hygiene, July 1970). He describes the New York State Department of Mental Hygiene program of 2 years of educational leave with pay for hospital orderlies who wish to become Mental Health Assistants by enrolling and completing a specially designed theory and practice program of study at their local Kingsborough Community College.

Interestingly, concurrent with these developments in the junior colleges, a lone individual in a few scattered universities, usually on his own initiative, was developing a similar 2-year program of study for college age youth wishing a direct entry into a mental health profession upon completion of their pre baccalaureate AA degree. One such program was developed on the Fort Wayne campus of Purdue University by Dr. John E. True from Purdue University and Mrs. Margaret Bell, Executive Director of the Mental Health Association in Allen County, Indiana. The graduate of this A. A. program is called a Mental Health Technologist and is ready to accept

employment as an allied professional in a mental institution or facility directly upon graduation.

With these scattered local developments, all isolated and none interrelated, it is not surprising that still other isolated institutions of higher learning took this development one or two steps further. In one of these, Dr. Herbert R. Zerof, Dean, Department of Mental Health Technology and Dr. Paul J. Fink, Director of Psychiatric Education, in the Department of Psychiatry at Philadelphia's Hahnemann Medical College developed a 4-year Bachelor of Science degree program in Mental Health Technology at their institution. And at Rockford's Northern Illinois University, faculty member Dr. Leonard Pecilunas teamed up with local mental health center worker Miss Maureen Elick to develop a Master of Arts program for another new mental health professional, the Mental Health Re-entry Expediter. The responsibility of this professional begins the moment a patient is admitted to a state hospital. He is the patient's advocate and, from that moment on, working with hospital staff and with the patient's family, employer, and significant others, his active responsibility is to keep all doors and avenues back into the community open for the patient. In this sense his responsibility is truly different from that of any member of the traditional core professions. He is a new professional with a set of responsibilities which takes into account the realities and problems associated with hospitalization and after-discharge. Preliminary evidence suggests the traditional core professionals are pleased with this new worker in their common battle.

Concurrent with these developments in the fuller utilization of auxiliary hospital personnel, comparable changes were taking place in the roles and responsibilities being assumed by the "Gray Ladies" and other types of dedicated women

volunteers working in mental hospitals and similar settings. Even as Margaret Rioch (1963) was training a few mature housewives for professional responsibility as one-to-one psychotherapists, comparable exciting new uses were being made of similar women volunteers in state hospitals and related settings throughout the country. Ewalt (1967) and Guerney (1969) provide excellent descriptions of highly imaginative uses of the housewives, businessmen, high school and college students and scores of other volunteers in direct services to the mentally and emotionally disabled in communities throughout our land. Fairweather, Sanders, Maynard, Cressler, & Black (1969) even extended this concept of the use of nontraditional manpower and developed what appears to be a highly successful program in which mentally ill patients, themselves, live in a lodge or similar community-based halfway house, from which they seek gainful employment and, collectively, serve as the active agent in their own return to the community.

Thus, in the period of the past few years, and with little or no communication among them, lone individuals working in state hospitals and related institutions have capitalized on the 1960 concept of the therapeutic community, with its key principle that all employees and volunteers and other patients are potential rehabilitators, and as appropriate in their setting have begun (1) inservice training programs, and new mental health educational programs leading, in some local settings, to (2) an Associate of Arts degree, or (3) Bachelor of Science degree, or (4) Master of Arts degree, or (5) entirely new rehabilitation and direct treatment programs. Happily, faculty members in psychology (and the other so-called core professions) appear to be welcoming these programs and thus give support to my guess that it has been the archaic machinery for change in institutions of higher learning and not personal-professional resistance

which has kept these new programs out of well-established universities. Results from two recent surveys of professional psychologists of their attitudes toward the training of such new mental health workers by Arnhoff and Jenkins (1969) and Thelen and Ewing (1970) confirm this strong acceptance by individual APA-member psychologists of these subdoctoral training programs. In addition, the current, apparently wide-based support in medicine for Physicians Assistants is, for me, a reflection of similar positive attitudes among psychiatrists.

But these developments in both professional practice (therapeutic community) and within our educational systems (AA, BS, and MA programs) appear to be only two of the three disparate streams which now appear to have joined and become a roaring river. The third stream was on outgrowth of the New Frontier and Great Society programs of Presidents John F. Kennedy and Lyndon B. Johnson. The efforts of their administrations on behalf of the nations poor, disadvantaged, and indigenous, and the large numbers of millions of dollars which they helped funnel on their behalf appear to have stimulated a surge of social consciousness in our nation's employers, unions, elected officials, and citizens more generally regarding new employment opportunities for these large masses of unemployed Americans that was unprecedented in our history. Influential leaders in this movement, recognizing the barriers to immediate entry into the private labor force, sought opportunities for these hundreds of thousands of indigenous Americans in already existing, or potential, newly proposed tax-supported programs. Working in or with the dozens of Inner City programs which sprouted overnight, and which served to relieve the joint problems of unemployment and welfare, imaginative individuals in select communities recognized that this vast pool of indigenous new workers constituted a valuable manpower resource for

working with this nation's mentally ill. The developments came to be known in some communities under the rubric of New Careers Program. One type of new Careerists is a person from the ghetto or other low-income community who, with minimal on-the-job training becomes the spokesman or communication link between his equally under-educated neighbors and his inner community's many, disparate and uncoordinated welfare and direct service (including mental health) institutions. With support primarily from the federal government, new programs were started in some inner cities wherein new careerists helped set up and operate city block, store front mental health screening, treatment, and referral centers. In a matter of the past several years such new career programs have recruited thousands of new mental health workers in such large cities as New York, Washington, Chicago, San Francisco, Sacramento and Venice, California, and Minneapolis. Descriptions and reviews of some of the New Career program developments has been provided by Riessman & Pearl (1965), Lynch, Gardner, & Felzer (1968), Henry & Kelly (1969), Fishman & McCormack (1969), and Mitchell & Terrell (1969), and Willcox (1970) among others.

It is probably clear, even from this short review, that over the past two decades hundreds upon hundreds of individuals, working alone in their own communities, have capitalized on their unique local resources and have taken giant strides in overcoming the acute shortages of traditional mental health manpower to meet the needs of their own patient (or client) charges. Thus, even without the direct help of organized professional societies or of institutions of higher learning, and by capitalizing on new developments in (1) professional practice, (2) the junior colleges, and (3) new social action programs such as New Careers, many of this country's communities have almost overnight increased the numbers of mental health workers

serving their communities by a factor of one, two, three or more. Some three or four years ago both the critical need for new numbers of traditional professional manpower and the early outlines of these unexpected developments in the utilization of nontraditional manpower began to show themselves to leaders in this country's organized volunteer mental health organization, the National Association for Mental Health. Inasmuch as this is a national organization of volunteers which, in common with the American Cancer Society and American Heart Association and similar groups, has the individual patient as its primary responsibility and not some organized national or local bureaucracy, the leadership of NAMH could move quickly to capitalize on what appeared to be these exciting new developments. In 1966-67 a Manpower Committee was formed by NAMH, and its initial members included one or two representatives of several of the core professions (see Matarazzo, 1968, pp. 165-167). Psychologists-members were Albee and Arnhoff, with the present writer as a member of the NAMH Board of Directors serving as chairman of the Committee.

Utilizing the full resources of NAMH, including many of its some 800 state and local chapters, and especially the thinking of some very influential leaders in the four core mental health professions, NAMH's Manpower Committee defined its initial role as that of serving as a further catalyst to the developments (described above) then coming together in 1967. The Committee quickly communicated to NAMH through three position papers (Albee, 1968b; Arnhoff, 1968; and Bettis, 1968) that the problem of a shortage of mental health professionals was not merely one of inadequate manpower. Rather, as these three papers were summarized for the NAMH membership by Matarazzo (1968, pp. 197-198), an analysis of this complex issue revealed that the alleged mental health manpower shortage was intimately related to (1) the

no longer viable conceptual framework regarding mental illness then held by many representatives of this country's mental health volunteer associations as well as core professionals; (2) the role of positive mental health in such a conception; (3) the role of poverty and other societal conditions in swelling the population in our public mental hospitals; (4) the realities of the current and future distribution of professional manpower (not the mere numbers of such professionals); (5) the probability that more such professionals and more community mental health centers (especially if available primarily in currently existing general hospitals) would only add to the current burden, rather than reduce it; (6) the need to re-order community thinking, as well as that of the four core professions, toward the concept that complex, societally-induced problems such as mental illness, with their concomitant social, cultural and educational ingredients, can conceivably more efficiently be surmounted if issues such as prevention and the utilization of other manpower resources (teachers, mental health expiditers, et al.), where appropriate, are considered and action is taken as indicated.

These three position papers and the above summary were presented to the NAMH membership at its annual meeting in November of 1967, and they led the following year to an official NAMH policy Statement on Manpower (April 1968). This official statement included the following passages:

> "What has NAMH learned from a study of this (manpower shortage) problem by a committee composed of a national group of lay and professional leaders in mental health? We have learned a simple but urgent and compelling fact: an overall look at these and related manpower demands for the delivery of mental health

> services quickly indicates that the problem will not be solved or even significantly approached by the recruitment and training of additional person in the traditional disciplines."
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> "Is there an alternative? . . . One recommendation . . . (is) that innovation and experimentation should be undertaken by the traditional professions to expand and develop the roles of allied and auxiliary personnel . . . (including indigenous personnel) through the use of mental health counselors to extend mental health services; and the use of volunteers, appropriately prepared and supervised, to augment manpower resources."

This NAMH Statement on Manpower has been disseminated widely throughout NAMH's 800 state and local chapters (including a summary in the April, 1969 issue of Mental Hygiene, pp. 161-162) and initial indications were that it had provided an excellent framework within which leaders in these localities could pursue unique approaches to their own local manpower requirements.

The following year, at the 1968 Annual Meeting, another member of the Manpower Committee, Cowne (1969) presented a much needed preliminary review of the many new developments in hospital practices, in junior colleges, in volunteer associations, in new careers programs, etc. which were taking place nationally and which have been reviewed above. Her report served as an important companion piece to the excellent review of many of these same developments independently published elsewhere by Arnhoff, Jenkins & Speisman (1969). A psychiatrist-member of the

Manpower Committee, Moody C. Bettis, also presented a report (Bettis and Roberts, 1969) at the 1968 Annual Meeting of a study of the total population of patients in the state-supported mental hospitals of Texas. Among other findings, Bettis' report confirmed one of the committee's formulations of the previous year; namely, that not all the patients sent to, or now housed in, a mental hospital are mentally ill and, therefore, any searches for solutions to the mental health manpower shortage should take into account a vast complex of societal issues not usually considered in a simplistic supply-demand-recruitment approach to the problem.

The first two year's of the Committee's existence were thus exciting ones and with the continuing support of the NAMH Board of Directors, including new Committee chairman Mrs. Wilbur Pell, a highly active long time volunteer mental health leader from Indiana, a nucleus of the earlier committee, and some new members, was encouraged to try to accelerate these national developments even further by selecting 35 of this country's most innovative and representative new mental health manpower programs and "showcasing" them in 1970 for highly selected, key leaders from each of the fifty states whose responsibility it would be to take back to their own state and local community program ideas appropriate to their own local needs and resources.

The three-day NAMH-sponsored Mental Health Manpower Showcase Conference, with partial funding from the Johnson Foundation and the Old Dominion Foundation, was held at the Marriott Motor Hotel in Washington, D. C. during February 11-13, 1970. In addition to today's symposium panelists Drs. Mase, Arnhoff, and Kumler; and previous committee member Albee, also invited to participate were a select group of 300 key leaders, including representatives from: (1) Mental Health Associations throughout the United States; (2) national leaders from the four core

professional societies and numerous allied professional societies; (3) leaders from the highest levels of government, private foundations, and national volunteer organizations; and (4) a unique group of pioneers representing 35 nationally innovative programs which it was the privilege of the showcase conference to highlight. The background for this unique mental health manpower showcase conference, and its hoped for objectives, have been described by the writer, who served as Showcase Conference chairman, in a recent publication (Matarazzo, 1970). In addition, one of the members of the Committee, who took a sabbatical year to serve as a volunteer in the NAMH office and helped the committee and staff to organize the showcase conference, has described some 18 of the 35 new mental health manpower programs which were showcased during the 3-day conference (Cowne, 1970).

This, then, is a short review of some of the new mental health manpower developments occurring in this country during the past two decades, and especially the catalytic role played by NAMH during the past four years. Fortunately NAMH did not see its responsibilities ending with the 3-day Showcase Conference. Built into the NAMH plan for the conference from the beginning was the pre-showcase conference appointment of a National Follow-Up Task Force with today's symposium panelist, Dr. Darryl Mase, Dean, College of Allied Health Professions, University of Florida, Gainesville as its chairman. His task force committee members include some of the most prestigious professional and lay leaders from NAMH, HEW, The Department of Labor, the core and allied mental health professions, and representatives of related groups and constituencies. NAMH charged the task force with the responsibility of reviewing the findings of the 3-day Showcase Conference and working toward the development of standards of recruitment of these new allied mental health professionals, training and uniform certification

requirements, as well as developing an operational research program aimed at evaluation of the human effectiveness and costs of these new programs on a local and national basis. From its inception, built into the Showcase Conference plan was the stipulation that each State Mental Health Association appointed a convener who, in addition to attending the conference, would be responsible for convening state committees (with lay and professional members) to review findings of the conference, to consider how these innovative programs can be applied to their local situations, and to plan in each state an action follow-up conference of appropriate state and local groups to evolve a plan for specific follow-up action to work on those aspects of the mental health manpower shortage, and its solutions, appropriate to its own interests and resources. The Follow-Up Task Force already has met twice in the first three months of its existence and one of its long range major responsibilities is the evaluation and coordination of these efforts within each of our fifty states.

This all too briefly related history is but another example of what local initiative, even in the absence of direct help from organized professional organizations, higher education, and organized federal, state and local government, can do to help in the solution of an acute manpower shortage problem of initially seemingly overwhelming proportions. The fight has not yet been won, but its scope and the local resources for meeting it at least have been identified and, in many communities, the shape of full or partial solutions already discerned. Most important is the renewed vitality and opportunity for self-renewal which these many disparate local programs have stimulated in auxiliary and allied professionals, volunteers, mental patients, themselves, and those of us working more directly and full time in education and the so-called core mental health professions.

This story would not be complete without a final happy note. One just published index that, concurrent with this active NAMH role, the many disparate, "grass roots" efforts reviewed above at last may have succeeded in breaking the log-jam and enigma associated with (a) interest by national organizations such as APA, and institutions of higher education in helping with these manpower shortages, on the one hand, but (b) helplessness to overcome university and national organizational inertia in order to put their efforts behind this real interest, on the other hand, comes from a recently published NIMH booklet: Innovations in Mental Health Training: Summaries of Experimental and Special Training Projects (June 1969). This publication contains capsule descriptions of 110 active or just completed NIMH training grants designed to support innovative approaches for training new types of mental health personnel. Projects designed solely for training of personnel in the four core disciplines are not included among this list of 110 funded projects. Rather, among many others, the list contains descriptions of training programs for Indigenous Mental Health Aids (University of Southern California; and Albert Einstein College of Medicine); Mature Women as Mental Health Rehabilitation Workers (Albert Einstein College of Medicine); AA degree Mental Health Workers (Purdue University); MA degree Child Development Consultants (University of Michigan; George Peabody College; and Florida State University); and MA Behavior Modification Child Workers (University of Kansas) among the 110. Review of the locations of the remaining programs in this 110 reveals the names of some of this country's most illustrious universities and other training centers. Thus, as happened in these same and similar universities during 1945-1950 when VA and USPHS monies became available for training vast numbers of members of the four core professions, these recently available

NIMH funds for training nontraditional mental health personnel resulted in application for, and the support of, 110 such projects at many of these same institutions.

A hint that the numbers of these university-based new manpower programs will increase is also contained in this same 1969 NIMH publication. Listed on page 51 is the capsule summary of a grant (MH-9525) to Dr. Arthur Brayfield, American Psychological Association, entitled: Use of Non-Professionals in Mental Health Work. This project, under the joint sponsorship of the American Psychological Association and the National Association of Social Workers, used this NIMH financial support to convene a two-phase conference on the use of non-professional workers in mental health. Phase one consisted of presentations on and discussions about various programs which are presently training and/or utilizing nonprofessional mental health workers. Resulting from Phase One were summaries of active programs, working papers, and a systematization of current experiences and issues which served as the focus for Phase Two. The Phase Two conference dealt with national policy implications in training and manpower development, and resulted in a major document on these vital issues entitled: _____.

Concurrent with these national manpower developments within the machineries of the American Psychological Association and the National Association of Social Workers, comparable developments have been occurring within organized Nursing and Medicine. For example, the American Medical Association has held a national Conference on (Nontraditional Medical) Manpower in Chicago in October of each of the past two years and has scheduled another for this October.

These developments leave little question in my mind that what began as a trickle of disparate, unorganized, one-man, grass roots programs in a few state

hospitals in the decade of the 1950's, and in a few junior colleges in the early 1960's, and in a few Inner Cities in the latter half of the 1960's, may soon be followed by an avalanche of such programs in still others of these facilities as well as in many of our most prestigious universities. The resulting further reduction of the numbers of patients in our mental hospitals will be but one of many byproducts of these unprecedented developments in the field of mental health manpower.

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